Dual Eligibles and Demand for Behavioral Health Services

California Public Stakeholder Meeting
December 2, 2011

2

Dual Eligibles: Disease Prevalence

- 1.1 million Dual Eligibles in California
  - 14% of Medi-Cal beneficiaries; 24% of total Medi-Cal costs (2007)

Disease	Prevalence Among Duals
Cardiovascular	54%
Psychiatric	52%
Central Nervous System	28%
Skeletal and Connective	22%
Diabetes	22%

Source: R.G. Kronick, M. Bella, T. Gilmer. *The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions*. Center for Health Care Strategies, October 2009.

3

Diagnosed Prevalence of Behavioral Health Disorders Among Dual Eligibles age 55+ in Mass. (CY '05)

Age	55-64 (%)		≥ 65 (%)	
	Duals	Medicare-only	Duals	Medicare-only
Any BHD	51.7	12.9	38.8	16.1
SMI	28.8	5.3	14.5	3.7
SUD	9.3	1.7	3.2	1.3
SMI with SUD	16.3	13.5	7.7	6.8
SUD with SMI	50	33	30	20
BHD & Dementia	15.4	9.2	51.7	29.4

Source: Clark, RE, et al, "Twelve-Month Diagnosed Prevalence of Mental Illness, Substance Use Disorders, and Medical Comorbidity in Massachusetts Medicare and Medicaid Members Aged 55 and Over, 2005" (2009). Clinical & Population Health Research Program. Paper 26. http://escholarship.umassmed.edu/gsbs_cphr/26

4

People with serious mental illness served by public mental health systems:

- Are **three times more likely** to have diabetes, ischemic heart disease, arthritis and heart failure than general Medi-Cal population (Jen Associates, 2007).
- Have a **31% increased** odds of being hospitalized in a given year.
- Die, on average, **25 years earlier** than the general population.

5

Source: California Institute for Mental Health. *Integration of Mental Health and Primary Care CPCI Learning Collaborative.* October 2011.

Dual Eligibles in California

- About 6% of all Dual Eligibles are in the Short-Doyle System
  - 68,000/1.1 million (10% more than in 2003)
- Duals comprised about 14% of 500,000 SD Medi-Cal beneficiaries and 11% of SD Funding | $220 million/$2 billion

Age Group	Funds	Clients (% of SD duals)	Per Capita SD Costs
TOTAL	**$221,358,186**	**68,076**	**$3,252**
0-20	$524,499	210 (2%)	$2,406
21-59	$172,761,092	49,390 (73%)	$3,498
60-64	$17,004,175	6,047 (9%)	$2,812
65+	$31,068,421	12,421 (18%)	$2,501

6

Source: Analysis of Short-Doyle Medi-Cal (SDMC) Approved Claims, Fiscal Year 2009-2010

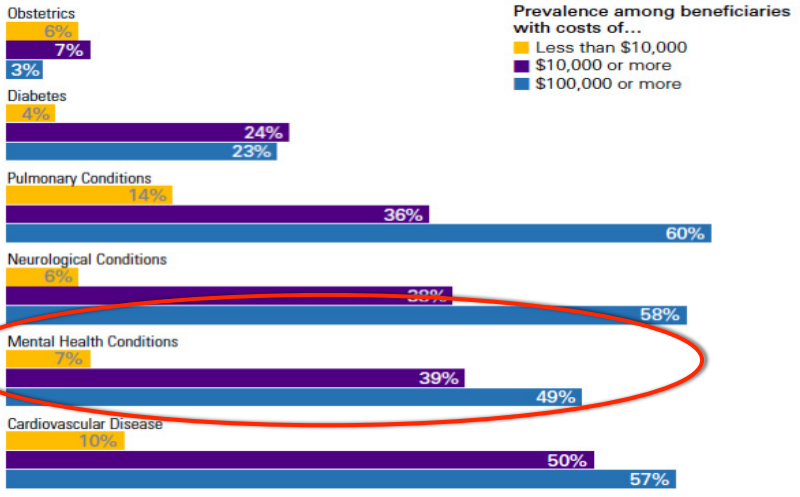
Duals in Short-Doyle Medi-Cal by County

Counties with 1,000 duals in SD	Dual Clients	% of State Total	SD Spending	Per Capita SD Spending
LOS ANGELES	16,829	25%	$50,043,051	2,974
SAN FRANCISCO	4,638	7%	22,270,168	4,802
ALAMEDA	3,488	5%	12,970,100	3,718
SAN DIEGO	3,276	5%	4,527,206	1,382
SANTA CLARA	3,226	5%	11,089,396	3,438
RIVERSIDE	3,123	5%	7,555,022	2,419
SAN BERNARDINO	2,931	4%	5,299,338	1,808
SACRAMENTO	2,372	3%	6,342,148	2,674
CONTRA COSTA	2,094	3%	7,127,094	3,404
SAN MATEO	1,979	3%	7,535,037	3,807
SAN JOAQUIN	1,770	3%	4,772,412	2,696
ORANGE	1,632	2%	3,294,012	2,018
KERN	1,495	2%	5,526,540	3,697
VENTURA	1,488	2%	4,596,251	3,089
FRESNO	1,393	2%	2,156,358	1,548
SANTA BARBARA	1,176	2%	7,654,797	6,509
BUTTE	1,032	2%	3,441,963	3,335

Source: Analysis of Short-Doyle Medi-Cal (SDMC) Approved Claims, Fiscal Year 2009-2010

7

Prevalence of Selected Conditions among high-cost Medi-Cal beneficiaries (FY 2008)



Notes: Reflects fee-for-service expenditures only. The number of beneficiaries with each condition is based on claims and/or encounters indicating the condition. Percentages do not total 100 percent due to comorbidity. See Methodology section for description of selected conditions.

Source: Lewin/Ingenix analysis of Medi-Cal MIS/DSS data for the 12-month period ending June 30, 2008 (extracted May 2009).

8

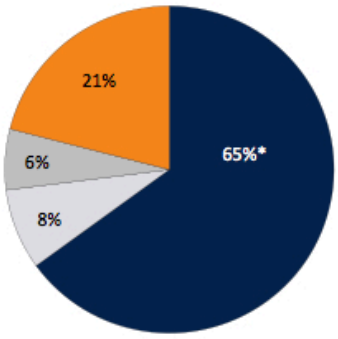
Challenges and Opportunities:
Coordinating Mental Health for Dual Eligibles

Neal Adams MD MPH
Deputy Director
CiMH

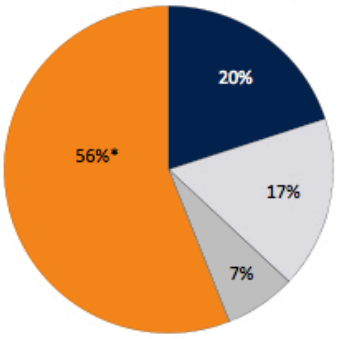
Basic Knowledge of Government Health Programs

To the best of your knowledge, which of the following government programs is the primary source of health insurance for…

…people over age 65 regardless of their income



…many low-income families regardless of their age

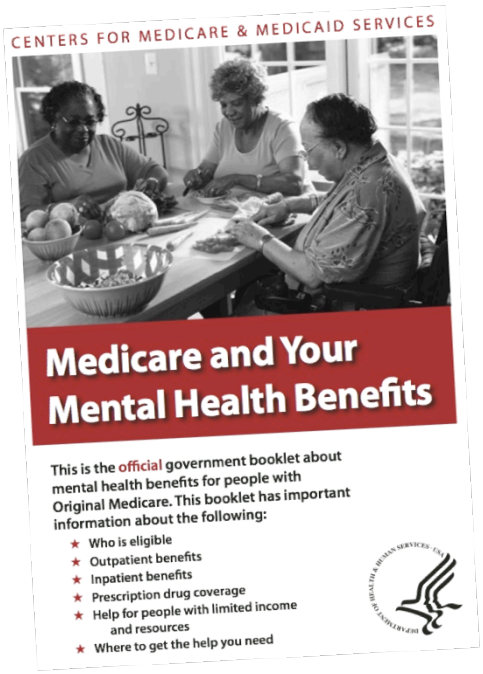


Medicare Medicaid Some other program Don't know/Refused

* Indicates correct answer.
Source: Kaiser Family Foundation *Health Tracking Poll* (conducted May 12-17, 2011)

Public Perception

- Just over half the public (56 percent) recognizes Medicaid as the government program providing coverage for many low-income families, regardless of age
  - a share that has increased slightly since 2005 (when it stood at 47 percent)
  - significant shares believe such coverage comes from Medicare (20 percent) or "some other government program" (17 percent)



Part A
- Inpatient

Part B
- Partial Hospital
  - Inpatient alternative
- Outpatient

Part D
- Prescriptions

…all have out of pocket co-pays…
…if you have Medicare and full Medicaid coverage, most of your health care costs are covered…

Out-Patient Part B

- Individual and group psychotherapy with doctors or certain other licensed professionals allowed by the state to give these services.
- Family counseling if the main purpose is to help with your treatment.
- Testing to find out if you are getting the services you need and/or if your current treatment is helping you.
- Psychiatric evaluation.
- Medication management.
- Occupational therapy that's part of your mental health treatment.

Rehab Option Criteria

- the person must have an *included diagnosis*
- the service must address a *significant impairment* in an important area of the person's life
- the service is expected to *significantly reduce* the impairment or *prevent significant deterioration* in an important area of the person's life
- a physical health provider cannot appropriately meet the person's needs

Rehab Option Services

- PHF
- Crisis Residential Treatment
- Adult Residential Treatment
- Crisis Stabilization
- Crisis Intervention
- Day Rehabilitation
- Intensive Day Treatment
- Medication Support Services
- Mental Health Services

Targeted Case Management

- Assist access to needed medical/ alcohol/drug treatment as well as educational, social, prevocational, and rehabilitative or other community services
  - Comprehensive and periodic assessment
  - Development and periodic review of a client plan
  - Referral and related activities
  - Monitoring and follow-up

Location Location Location

- Medicare
  - Facility or office-based only
  - Includes free-standing psychiatric hospitals
- Medi-Cal
  - Office and field-based services
  - Only PHFs and psychiatric units of general medical hospitals between ages for adults

Continuum of Care

- LOCUS
  - Prevention and health maintenance
  - Low-intensity community based services
  - High-intensity community based services
  - Medically monitored non-residential services
  - Medically monitored residential services
  - Medically managed residential
    - includes hospital as well as alternatives

Fundamental Differences

Medicare

- Medical
- Location dependent
- Narrow range of providers
- Co-pays
- JCAHO
- Some managed care
- Provider participation and availability
- Telemedicine barriers

Medi-Cal

- Rehabilitative
  - recovery and resiliency focused
- Location independent
- Wide range of providers
- No co-pays
- CARF
- SPDs and fee-for-service
- County MHPs
- Telemedicine routine

In conclusion…

- Opportunities
  - Decrease fragmentation / increase coordination
  - Improve access
  - Improve quality and outcomes
  - Better utilize resources
- Challenges
  - Simplify rather than “complexify”
  - Person-centered solutions
  - Sacrificing quality for efficiency
  - Preserve choice and continuity of care

Drug Medi-Cal and Dual Eligibles

Bill Manov, Ph.D.

December 2, 2011

25

Drug Medi-Cal

- Limited Benefit and Rates
  - Methadone $11.86
  - Day Care Rehabilitative $63.86
  - Outpatient Individual $69.59
  - Outpatient Group $29.57
  - Perinatal Residential $92.45
- $246M statewide ($116M FFP + $130M match)
- Limited Eligibility – SUD is not a qualifying disability
- No Rehab Option – Services within 4 walls; no case management
- Realignment puts counties at-risk for DMC growth

26

SUD Services and 1115 Waiver (LIHP)

- SUD is not a required LIHP benefit – counties must supply match
- Statewide SUD and MH needs assessment and plan required by CMS
- 8 counties included SUD as optional add-on LIHP service
  - 3 counties will use LIHP as match to broaden continuum of SUD treatment services (San Francisco, San Mateo, Santa Clara)
  - 5 counties will target LIHP SUD services to substance abusers in highest cost primary care and mental health settings (Alameda, Kern, Orange, Riverside, Santa Cruz)
- 34 CMSP counties will include 20 outpatient SUD visits per year (based on pilot evaluation)
- LIHP as opportunity to study impact of SUD services on medical utilization and costs

27

Cost Benefit of SUD Services on Medical Costs

- High prevalence of SUD in Medicaid and PC clinic populations (29% per Clark et al., 2009; 23% per Brown et al, 2001) associated with higher medical care costs
- Cost Benefit of SUD services
  - Washington State (Manusco & Felver, 2010) expanded SUD services to Medicaid disabled (some duals) and GA had $2 - $1 ROI on medical and nursing facility costs
  - Kaiser (Ray et al., 2000) – integrated SUD in PC setting reduced PMPM cost from $470 to $227 due to decreased inpatient and ED usage

28

SUD Essential Benefits

- CADPAAC and Coalition for Whole Health
  - Assessment
  - Outpatient and Intensive Outpatient
  - Residential Treatment
  - Detoxification
  - Medication-Assisted Treatment
  - Lab Services (including Drug Testing)
  - Case Management and Collateral Services
  - Clean and Sober Housing
  - Recovery Supports
  - Preventive Services and Chronic Disease Management

29

SUD Medicaid Benefits – The Future

- ACA requires HHS to determine "Essential Benefits" for SUD and MH for Medicaid expansion and private managed care plans
- Parity – deductibles, cost sharing, lifetime/annual caps, non-quantitative exclusions (e.g., fail first)
- Drug Medi-Cal is "carved out" and fee for service - Will essential benefits and parity apply?
- IOM Report – balancing comprehensiveness and cost: typical small business benefit package
- Milliman study – inpatient detox and outpatient counseling covered; approx 60% cover residential treatment; $6.50 - $7.90 PMPM for SUD/MH coverage (approx 2% of PPO cost)
- HHS determination of essential benefits in January 2012?
- Impact of realignment and carve-out?

30

Thank you

Bill Manov, Ph.D.

Santa Cruz County Alcohol and Drug Program

Bill.manov@health.co.santa-cruz.ca.us

(831) 454-4220

31

CHCS
Center for Health Care Strategies, Inc.

Integrating Physical and Behavioral Health: Two Design Options for People Eligible for Medi-Cal and Medicare

Friday, December 2, 2011

Alice Lind, CHCS Senior Clinical Officer

Why Integrate?

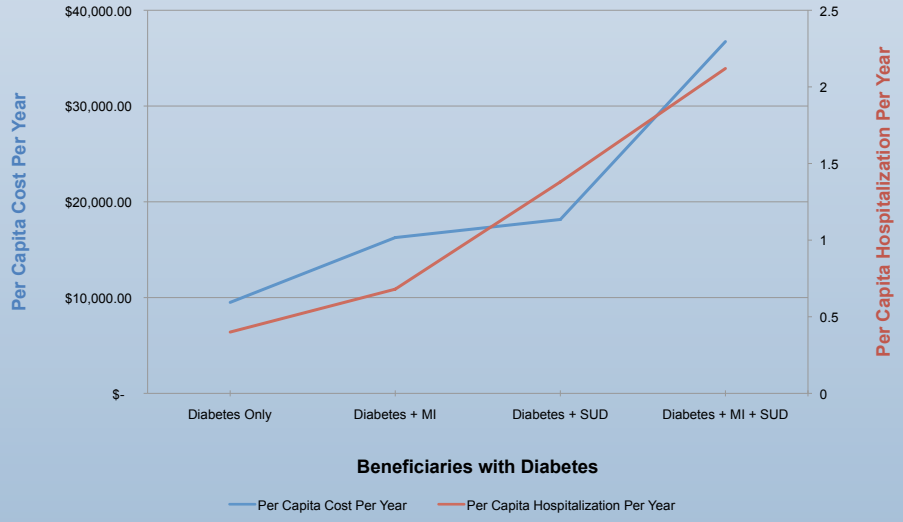
- 1 out of 2
  - Half of beneficiaries with disabilities have Behavioral Health comorbidity
- 3 to 4
  - Addition of mental illness and substance use disorder to chronic medical population is associated with 3-4x increase in costs
- 25
  - Years of lost life expectancy associated with serious mental illness, primarily due to physical health issues
- 5/50
  - Top 5% drives 50% of Medicaid spending

*Sources: RG Kronick et al., "The Faces of Medicaid III: Refining the Portrait of People with Multiple Chronic Conditions." Center for Health Care Strategies, October 2009; C. Boyd, et al. "Clarifying Multimorbidity for Medicaid Programs to Improve Targeting and Delivery of Clinical Services." Center for Health Care Strategies, December 2010.

CHCS Center for Health Care Strategies, Inc.

33

Impact of Mental Illness & Substance Use Disorders on Cost and Hospitalization for People with Diabetes



CHCS Center for Health Care Strategies, Inc.

SOURCE: C. Boyd et al. *Faces of Medicaid: Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services.* Center for Health Care Strategies, December 2010.

34

Key Elements of Integrated Models

- Beneficiary-centered, holistic care model
- Aligned financial incentives
- Information exchange
- Multidisciplinary care teams accountable for coordinating the full range of services
- Competent provider networks
- Mechanisms for assessing and rewarding high-quality care

Physical and Behavioral Health Integration Options

1. **Managed Care Organization (MCO) as Integrated Care Entity**
2. State Primary Care Case Management (PCCM) Program as Integrated Care Entity
3. Behavioral Health Organization (BHO) as Integrated Care Entity
4. **MCO/PCCM and BHO* Partnership Facilitated by Financial Alignment**

*BHO or other non-capitated provider of mental health services

PHYSICAL/BEHAVIORAL HEALTH INTEGRATION OPTIONS

- ***OPTION 1* - Managed Care Organization (MCO) as Integrated Care Entity:** Benefits and financing for physical and behavioral health services are integrated within managed care contracting arrangements.
  - *Considerations*: whether to allow subcontracting; performance/contracting requirements to address BH competencies; readiness and capacity of plans to manage BH services; payment policies that facilitate effective care coordination.
  - *Beneficiary perspective:* One go-to person; single plan of care; easier to identify gaps in care.
  - *Examples*: Minnesota, Tennessee, Washington

OPTION 1: MCO as Integrated Care Entity

PROS

- Aligns incentives and promotes coordinated care
- Fully integrated administrative data for care management
- Seamless access to benefits & services
- Potential for true clinical integration
- True to CMS demonstration model for people dually eligible for Medicare/Medi-Cal

CONS

- Potential for cost-shifting
- Lack of specialized clinical capacity
- Subcontracts can undermine true integration
- "Specialized" MCOs for SMI population are a new, untested approach

PHYSICAL/BEHAVIORAL HEALTH INTEGRATION OPTIONS

- ***OPTION 2* – MCO & BH Partnership**: Within a carve-out environment, create aligned financial incentives by implementing shared savings or other performance-based incentives to reward integration.
  - *Considerations*: develop appropriate performance standards in MCO and BH contracts; **establish clear data sharing/privacy guidelines for information exchange**; provide integrated data directly to MCO and BH partners.
  - *Beneficiary perspective:* Might require action (consent; identifying primary care manager).
  - *Example*: Pennsylvania

OPTION 2: MCO/PCCM & BHO Partnership

PROS

- Avoid major system overhaul
- Share savings with providers to support care management
- Promote specific priorities through performance measures
- Greater access to necessary BH services

CONS

- Shared savings can be challenging to implement
- Information exchange may be hindered by carve-out environment
- Separate systems remain, thus potential for fragmented care
- BHOs will likely need to partner with multiple MCOs

For More Information

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services.
- **Subscribe** to e-mail Updates to learn about new programs and resources.
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

www.chcs.org

www.integratedcareresourcecenter.com

CHCS Center for Health Care Strategies, Inc.

41

Mental Health and Substance Use Coordination in California's Duals Demonstration:
San Mateo County Approach

Stephen Kaplan LCSW
Director Behavioral Health and Recovery Services
December 2, 2011

42

Background

- County Organized Health Plan
  - Health Plan of San Mateo (HPSM)
- 8,300 members of HPSM Special Needs Plan for dual eligibles
- BHRS- 26% duals
- High Co-Occurring Prevalence
- BHRS subcontractor for SNP members complex issues
- Primary Care less serious MH/SU issues

43

Proposed Integrated Care Model

1. Consumer directed care
2. Single Point of Entry (SPOE) and uniform assessment
3. Care management via interdisciplinary teams
4. Leveraging of existing county and community resources
5. Flexibility to provide services based on individuals' needs

44

Specific Care Integration Challenges

- Integrated care in health home and behavioral health homes
- Focus on care management for persons with poorest health outcomes
- "New" population for substance use providers
- Fragmentation between MediCal, Medicare, and FQHC funding structures and rules

45

Assessment and Care Planning

- Single Point of Entry
  - "Virtual" SPOE
  - Uniform Assessment Tool
- Care Plan
  - Individualized-preventive, primary acute, behavioral and long-term care

46

Interdisciplinary Care Teams

- Consumer, AAS, HPSM, PCP, In-home providers, BHRS
  - Developing evidence-based individualized health and social service care plans
  - Identify participants transitioning levels of care
  - Ensure participants are actively involved
  - Monitor care delivery
  - Reassessment of participants needs

47

Mental Health and Substance Use Enhancements

- Further Primary Care/BHRS integration and co-location
- Total Wellness
- SU Continuum of Services
- Behavioral Health Homes

48

LIHP Substance Use Services

- Screening, Diagnosis and Assessment
- Residential Detoxification
- Residential Services
- Intensive Outpatient Services
- Outpatient Services
- Medication Assisted Treatment
- Case Management
- Management of co-occurring disorders

49

Anticipated Benefits

- Blended Funding = Treatment Plans based on needs and not on categorical restrictions
- Focus on poorest health outcomes
- Financial incentives = People live in least restrictive environments
- Health Care Home Access
- MUCH Better Care Coordination
- Blended data will help target efforts at most complex clients

50

CONTRA COSTA
HEALTH SERVICES
MENTAL HEALTH DIVISION

CARE COORDINATION IN CALIFORNIA'S DUAL ELIGIBLES DEMONSTRATION: MENTAL HEALTH, SUBSTANCE USE AND MEDICAL CARE SERVICES

Contra Costa County: A Two Plan Model
Suzanne Tavano, BSN, PH.D.
Acting Mental Health Director

51

CONTRA COSTA COUNTY CONTEXT

- Ninth Largest California County
- Population 1.2 Million
- Two Plans: Contra Costa Health Plan (CCHP) and Blue Cross
- Contra Costa Health Services Organizational Structure
- Contra Costa Mental Health Plan Services Approximately 18,000/YR
  - FY 09/10
    - Children 6,323
    - Adults 10,950
    - Older Adults 1,158
- 25% of the Adult Consumers Served Are Dual Eligibles

52

CURRENT INTEGRATION INITIATIVES

- IMPACT: Depression Care for Older Adults
- CalMEND: Integrated Treatment for Complex Needs
- Concord Wellness Center
- Peri-natal Depression Project
- Contracts with Community Clinics for Integrated Care

53

LESSONS LEARNED

- Care Coordination in Co-Located versus Distinct Site Locations
- Electronic Health Record: The Communication Bridge
- Integrated Assessment
- Integrated Treatment Plans
- Importance of Transportation
- Partnering with Community Resources
- Role of Peer Providers
- Role of Consumer in Self-Care and Management

54

SPECIALTY MENTAL HEALTH: MORE THAN THE MANAGED CARE "CARVE OUT":

- The 1915 B Waiver
  - 1995-1997 MEDI-CAL Mental Health Consolidation: Managed Care
  - Increase in Access to Care
  - Care Management Across Service Continuum
  - Emphasis on Home and Community Services
- Two Important State Plan Amendments; Rehabilitation and TCM
- Funding: FFP, Realignment, County Funds, MHSA, LIHP, M/C Managed Care
- The Expanded Role of Community (Specialty) Mental Health
- Four Quadrant Model

55

POTENTIAL BENEFITS AND CONCERNS

BENEFITS:

- Coordinated Management of Benefits and Care: The Treatment Team
- Wellness and Recovery versus Medical Model
- Increased Prevention and Early Intervention

CONCERNS:

- Reduction in MEDI-CAL Benefit to Mirror MEDICARE Benefit
- Reduction in Community Focus with Return to Clinic Model
- Inadequate Array of Substance Use Services
- Remaining Myths and Barriers to Sharing Clinical Information

56


More info at www.CalDuals.org
Contact us at info@CalDuals.org
Track updates on Twitter
@CalDuals